Agency:	**107** Health Care Authority
Decision Package Code/Title:	**PL-KE Audit Oversight**
Budget Period:	**2014 Supplemental Submittal**
Budget Level:	**PL –** Policy Level

Recommendation Summary Text

The Health Care Authority (HCA) requests $1,028,000 ($514,000 GF-State) and 4.0 FTEs in the 2014 Supplemental to establish an audit and compliance section. This section is necessary to meet statutory requirements for an internal audit function and to address the critical need as the single state Medicaid agency to monitor activities across multiple entities such as Health Benefit Exchange (HBE), Department of Social and Health Services (DSHS), Department of Health (DOH), Medicaid Administrative Match (MAM), Department of Early Learning (DEL), etc.. This is also to respond to the increase in state and federal oversight of Medicaid financial management and program integrity by Centers for Medicare and Medicaid Services. Focused dedication to these areas will ensure federal funds are properly leveraged and thereby mitigate the budget risk to the state.

Package Description

HCA has been delegated the Medicaid single state agency of Washington State. The Financial Services Division (FSD) works in collaboration with the other HCA divisions and a variety of external agency stakeholders and partners to provide financial services and financial management for both Medicaid and Public Employee Benefits (PEB) activities. HCA provides access to quality health care services for public employees and for Washington's most vulnerable citizens. HCA strives to be a prudent purchaser of health care services. Part of HCA's responsibility in being a prudent purchaser is to ensure proper accounting for its fiscal resources.

The audit and compliance section in the FSD would serve as an independent, objective assurance and consulting resource designed to add value and improve the agency's operations. This objective is accomplished by implementing a systematic, disciplined approach to evaluating and improving the effectiveness of risk management, control, and governance processes. Under the direction of the Chief Financial Officer (CFO), the audit and compliance section would provide professional assurance and advisory services to executive management. These services would support the achievement of strategic objectives by strengthening the level of performance and accountability of the agency's operations.

The audit and compliance section would be responsible for conducting internal audits and program reviews to determine whether the agency's operations:

- safeguard assets,
- comply with laws and other applicable requirements,
- maintain data and system confidentiality, integrity, and availability,
- achieve organizational goals, and
- use resources efficiently.

In addition, as the Medicaid single state agency, the HCA has final authority over Medicaid programs and has the responsibility to exercise administrative discretion in the administration and supervision of the Medicaid State Plan. While certain administrative duties are delegated to other entities, the HCA is ultimately accountable for and has oversight responsibility over the expenditure of any Medicaid funds across a variety of external entities (HBE, DSHS, DOH, MAM, DEL, etc.).

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A dedicated audit and compliance section is severely needed to manage multi-entity oversight responsibility. The section would perform periodic examinations and follow-up reviews of the accounts, records, procedures, and policies of the State's Medicaid Program, and the administrations and facilities, to help safeguard the agency's assets by minimizing various internal control risks.

Finally, the National Association of Medicaid Directors (NAMD – attached to this DP) has noted several dynamics at the national level, including the implementation of the Affordable Care Act (ACA), which will drive increasing federal oversight of numerous programmatic and financial aspects of the Medicaid program. Congress and the Administration plan to undertake extensive monitoring and oversight activities to determine the value of enhanced federal expenditures. These efforts also carry undertones of mistrust of states to manage federal dollars.

A dedicated audit and compliance section would ensure that the HCA is prepared to handle more intense and sustained federal requirements from Congress and the Administration, including the U.S. Department of Health & Human Services' Office of Inspector General (OIG). Federal reporting, monitoring, and oversight requirements for Medicaid will take on more stringency. These pressures are compounded by the magnitude of the ACA's new program and policy changes and the short timeframes for implementation.

Questions related to this decision package should be directed to Wendy Tang at (360)725-0456 or at Wenfang.Tang@hca.wa.gov.

Fiscal Detail/Objects of Expenditure

	FY 2014	FY 2015	Total
1. Operating Expenditures:			
Fund 001-1 GF-State	$ 265,000	$ 249,000	$ 514,000
Fund 001-C GF-Federal Medicaid Title XIX	$ 265,000	$ 249,000	$ 514,000
Total	**$ 530,000**	**$ 498,000**	**$ 1,028,000**

	FY 2014	FY 2015	Total
2. Staffing:			
Total FTEs	4.0	4.0	4.0

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	FY 2014	FY 2015	Total
3. Objects of Expenditure:			
A - Salaries And Wages	$ 342,000	$ 342,000	$ 684,000
B - Employee Benefits	$ 97,000	$ 97,000	$ 194,000
C - Personal Service Contracts	$ -	$ -	$ -
E - Goods And Services	$ 58,000	$ 58,000	$ 116,000
G - Travel	$ 1,000	$ 1,000	$ 2,000
J - Capital Outlays	$ 32,000	$ -	$ 32,000
N - Grants, Benefits & Client Services	$ -	$ -	$ -
Other (specify) -	$ -	$ -	$ -
Total	**$ 530,000**	**$ 498,000**	**$ 1,028,000**

	FY 2014	FY 2015	Total
4. Revenue:			
Fund 001-C GF-Federal Medicaid Title XIX	$ 265,000	$ 249,000	$ 514,000
Total	**$ 265,000**	**$ 249,000**	**$ 514,000**

Narrative Justification and Impact Statement

What specific performance outcomes does the agency expect?

Funding this package would allow HCA to provide program management and oversight of the Medicaid program to facilitate and support access to high-quality, affordable health care services.

Performance Measure Detail

Activity Inventory
H001 HCA Administration

Is this decision package essential to implement a strategy identified in the agency's strategic plan?

Yes. This request supports the HCA goal to improve health care quality and access and to improve internal and external partnerships by providing needed resources to meet state and federal requirements.

Does this decision package provide essential support to one of the Governor's priorities?

Yes. This request supports Governor Inslee's Results Washington - Goal 4: Healthy and Safe Communities, and Goal 5: Effective, Efficient and Accountable Government.

Does this decision package make key contributions to statewide results? Would it rate as a high priority in the Priorities of Government (POG) process?

Yes. This request supports priorities related to the sustainability of health care.

What are the other important connections or impacts related to this proposal?

This package impacts HCA's ability to provide efficient program management and oversight of the Medicaid program.

What alternatives were explored by the agency, and why was this alternative chosen?

The alternative is to not fund an audit and compliance section. This raises the possibilities of the following:

- Reduction of program management and oversight
- Increased risks of being out of compliance with state and federal requirements
- Increased risks of negative audit findings
- Significant fines and penalties

HCA has chosen to request funding of this package to avoid these negative consequences.

What are the consequences of not funding this package?

Not funding this package would limit HCA's ability to conduct internal auditing and program monitoring to ensure state and federal funds are spent in accordance with rules and regulations. HCA would face increased risks of negative audit findings and of being out of compliance with state and federal requirements. Non-compliance may result in missed opportunities to reduce fraud, waste and abuse in the Washington Medicaid program.

What changes would be required to existing statutes, rules, or contracts, in order to implement the change?

No changes would be required to existing statutes, rules, or contracts, in order to implement this package.

Expenditure and Revenue Calculations and Assumptions

Revenue Calculations and Assumptions:

HCA assumes that the positions requested will be eligible for federal Medicaid administrative match funding equal to fifty percent of the total cost.

Funding Distribution

		FY 14	FY 15	Total
Distribution Methodology:	State-Fed 50/50			
001-C GF-Federal Medicaid Title XIX	50.00%	265,000	249,000	514,000
Total		**265,000**	**249,000**	**514,000**

Expenditure Calculations and Assumptions:

HCA assumes that the positions requested will include one audit manager, two audit staff, and one audit assistant. Staff costs are estimated based on agency averages for one Band 3 audit manager, two Band 2 audit staff, and one Band 1 audit assistant. In addition to staff costs, there are one-time costs for furniture and equipment (computers, phones, chairs, work station set up, etc.)

Which costs and functions are one-time? Which are ongoing? What are the budget impacts in future biennia?

Distinction between one-time and ongoing costs:

With the exception of equipment to support the new positions, all staff costs are ongoing.

Budget impacts in future biennia:

With the exception of equipment to support the new positions, all staff costs will carry forward into future biennia.

To: Medicaid Directors

From: NAMD staff

Re: Enhanced federal oversight of financial management and program integrity

Date: July 9, 2013

NAMD is engaged in ongoing conversations with federal Administration officials, congressional staff and other entities regarding Medicaid financial management and program integrity issues. This memo updates directors on the overarching climate and specific initiatives underway. We also provide issues for your consideration.

Background

Several dynamics at the national level will continue to drive increasing oversight of numerous programmatic and financial aspects of the Medicaid program. At a high level the Affordable Care Act (ACA) remains an extremely polarizing issue between the two political parties. This creates opportunities for opponents as well as supporters of the ACA to pursue extensive monitoring and oversight activities. However, the enhanced scrutiny is not limited to ACA issues. NAMD has noted clear indications that states should be prepared for increased oversight in all aspects of their programs, from financing mechanisms to managed care contracting to program integrity efforts.

Of particular import for Medicaid directors, the ACA established several new optional programs for states that provide enhanced funding, including but not limited to the eligibility expansion. States also will receive enhanced funding to comply with certain mandatory changes relating to modernization of their eligibility systems. Congress and the Administration plan to undertake extensive monitoring and oversight activities to determine the value of these federal expenditures. These efforts also carry undertones of mistrust of states to manage federal dollars.

Federal reporting, monitoring and oversight requirements for Medicaid will take on more stringency, similar to what states were subject to under the American Recovery and Reinvestment Act (ARRA). However, state Medicaid directors should be prepared for more intense and sustained federal requirements from Congress and the Administration, including the HHS' Office of Inspector General (OIG). These pressures are compounded by the magnitude of the ACA's new program and policy changes and the short timeframes for implantation.

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CMS SMD on Financial Management

On March 18, 2013, CMS sent a letter to state Medicaid directors outlining new strategies in federal and state oversight of Medicaid expenditures.[1] In it CMS shared three major updates:

- The CMS would form an executive workgroup with NAMD to focus on financial management and program integrity-related issues;
- The CMS plans to institute regular, ongoing "check-ins" with states to review expenditures, claims, audits, and other areas of potential exposure for states; and
- Every state is subject to new UPL reporting requirements as described in the letter and supporting guidance, effective July 1, 2013.

In addition to these specific issues, directors may be well served to consider the broader implications of the CMS' letter, and begin preparing now for this increased oversight.

Areas of Enhanced Federal Financial Management

The March 2013 CMS letter and recent statements by various federal officials consistently signal a major shift in the agency's approach to financial management and oversight of Medicaid expenditures. CMS is moving away from a relatively passive approach to take a notably more active role in fiscal oversight activities.

Financial oversight. Most immediately, CMS is focused on its fiduciary responsibilities to ensure appropriate expenditure of federal funds. For example, CMS is in the process of developing policy parameters that will govern financial oversight of enhanced federal funds in states that take up the new eligibility expansion option. CMS is in the very early stages of developing the parameters, and plans to share more information with all states later this summer or early fall. This timeline may prove challenging to states if they need to modify health plan contracts or plan to start open enrollment on October 1, 2013. The CMS' activities will focus on:

- Strategies to mitigate risks related to rate setting for newly eligible enrollees. As part of this the CMS' Center for Medicaid and CHIP Services (CMCS) and Center for Program Integrity (CPI) may reach out to states.
- Meetings with states to discuss risk mitigation strategies;
- Strategies for current Medicaid plans and alternative benefit plans (ABP); and
- Preparation for 2014 rate setting.

[1] See SMD #13-003 Re: Federal and State Oversight of Medicaid Expenditures at: http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-003-02.pdf

While applicable only to the so-called "expansion states" in the short-term, states should be prepared for these policies to be extended to all states at some future date. For example, for some time, CMS has been considering updates to rate or payment-related guidance documents, such as the "checklist" the CMS Regional Offices use to confirm the actuarial soundness of rates for capitated managed care programs.[2] CMS also still plans to update federal managed care regulations. Experience with these new policy parameters for the expansion states are likely to inform CMS' subsequent rule-making and clearance activities.

States report enhanced oversight in other areas. As previously stated, CMS already established new reporting requirements for UPL demonstrations. NAMD has heard from states that federal officials also are actively reviewing state policies in at least the following areas:

- Medicaid Administrative claiming programs
- Personal care services programs
- Managed long term-care services and supports

Federal staff capacity supports shift in focus. In recent years CMS hired additional staff largely to focus on policy development and implementation of the ACA's initiatives. More recently, CMS has begun to build capacity in divisions responsible for financial management and oversight and PI-related activities.

For example, CMCS continues to grow its managed care staff, including adding actuarial experts. While CMS is well behind the state movement to the managed care model, this is notable because it will allow CMS to engage more deeply with states in the rate-setting process. In addition, CPI hired at least one new Medicaid policy expert who will serve as a senior advisor to the CPI director, Dr. Peter Budetti. The CPI's Medicaid group also is in the process of modifying its audit and related PI work to ensure these are pertinent to the federal and state needs. The OIG also has brought on additional staff.

NAMD expects an ongoing expansion or redirection of federal staff to focus on financial management and program integrity in the traditional fraud and abuse arena.

Performance Indicators and Accountability

CMS is currently laying the groundwork for a greater focus on state program performance and accountability. Specifically, one area of CMS' focus is development of performance indicators that would help to describe how well systems are working as well as the experience of consumers. CMS is initially focused on eligibility and enrollment indicators, but the agency has already floated plans to develop provider-focused indicators at some point in the future. CMS is currently working with a

[2] See Government Accountability Office report GAO 10-810, "Medicaid Managed Care: CMS's Oversight of Rate Setting Needs Improvement," August 2010: http://www.gao.gov/new.items/d10810.pdf

small group of states to clarify draft indicators and feasible reporting frequency. These will be applicable to all state Medicaid programs. The frequency and depth of the indicators will evolve over time.

NAMD is mindful of the calls by some at the federal level for tying the performance or outcomes of state Medicaid programs to federal financial participation (FFP). However, there is no imminent plan to do so at this time. NAMD is continuing to closely monitor and engage federal officials in these areas.

Traditional Program Integrity Fraud and Abuse Activities

CMS' shift to a more active role in financial management of federal and state Medicaid expenditures does not replace or diminish the fraud, waste and abuse activities traditionally handled by the CPI and HHS' Office of the Inspector General (OIG). As states are well aware, the OIG has a very extensive work plan for the remainder of federal fiscal year 2013.[3] NAMD anticipates a similarly rigorous and expansive work plan for the years ahead.

In recent years, the CPI's resources have not kept pace with either the growth or increasing sophistication and complexities of the Medicaid program. NAMD anticipates that Congress will support additional resources for the OIG and CPI to carry out these activities.

Congressional Oversight and PI Activities

Key members of Congress already have or plan to introduce comprehensive program integrity related bills.[4] To date Medicaid (and Medicare) PI initiatives in the Senate have largely been bipartisan.

Two other factors will drive the focus on program integrity and oversight by the Congress. First, there is a limited appetite for additional federal spending, which historically means Congress increases its oversight initiatives. Also, we are naturally in a lull of congressional activity as the ACA is implemented. After the implementation phase Congress will need time to reevaluate the structural components of the Medicaid program, including financial mechanisms and outcomes.

Issues for Consideration

[3] See HHS OIG Work Plan, Fiscal Year 2013: http://oig.hhs.gov/reports-and-publications/archives/workplan/2013/WP03-Mcaid.pdf

[4] See Press Statement of Sen. Tom Coburn, June 10, 2013: http://www.coburn.senate.gov/public/index.cfm/rightnow?ContentRecord_id=2a161888-9c12-415b-b60f-7f8d44f13991 and Senate Finance Committee news release, "Bipartisan Finance Committee Report Details Policy Recommendations to Combat Waste, Fraud & Abuse in Medicare & Medicaid," April 24, 2013: http://www.finance.senate.gov/newsroom/ranking/release/?id=47ab6c07-06e7-4479-a245-d32a3199aafe

The following are several questions Medicaid directors may wish to consider in light of the federal direction described in this memo.

ACA-Implementation related issues

NAMD anticipates that regardless of the state's decision to take up the eligibility expansion, state agencies can expect to receive numerous questions from federal and state policymakers, think tanks and researchers, and the media.

- How is the state planning to evaluate the experience as new systems and programs come on-line? What specific indicators will you track? Will the state indicators align with the federal indicators?

- What systems changes might you have to make to comply with the federal performance indicators reporting requirements in the short and long term (once the indicators are defined)?

- Does the state have sufficient documentation that it has adhered to federal guidelines and standards for enhanced funding for eligibility systems? For any other programs the state receives enhanced federal funding (e.g., primary care rate increase)?

Financial management and oversight

- How will you allocate resources to responding to a rise in federal oversight and research requests from Congress, CMS, the GAO, and other interested entities? What new expertise and/or practices might you need to ensure you can respond to these expectations?

- The OIG's work plan reveals the areas they will focus their investigations. Has the state reviewed the OIG's Medicaid work plan and identified potential areas of exposure among the issues listed? Are you working to address these? If so, have you developed corrective action strategy? If CMS is not engaged with the state on this, are there federal resources they could contribute that would be helpful?

- In states that are expanding eligibility per the new ACA option or bringing up other programs for new populations, how will you ensure the accuracy of the capitation payments and/or provider rates? Will these be periodically reviewed?

- What role does your Program Integrity Director (or similar staff) have in development of new provider contracts/agreements? In development of new programs, such health homes and other community-based programs established by the ACA?